Justice Manitoba
Manitoba Justice

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OFFICE OF THE CHIEF MEDICAL EXAMINER

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ANNUAL REVIEW

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TABLE OF CONTENTS

Historical Background 1

Introduction 3

Caseload Statistics 5

Types of Death Investigated and Certified 7

- Homicides 7
- Suicides 7
- Traffic Accidents 9
- Non-traffic Accidents 10
- Natural Deaths 11
- Children-in-Care 11
- Sudden Infant Death Syndrome 12
- Undetermined Deaths 12

Inquests 13

Judical Recommendations..... 15

HISTORICAL BACKGROUND

(Coroner System - Medical Examiner System)

The Medical Examiner and the Medical Examiner system has evolved from duties which were assigned to Coroners and systems put in place to effect the legislated and non-legislated responsibilities of the office.

The word coroner is a derivation from the old French spelling of the word "crown". The office of "Crowner" (crown representatives) was originally established to secure revenues which accrued to the crown in the event of sudden or unexplained deaths.

The first detailed statute on the office of coroner was the 1275 Statute of Westminster which established the office for revenue purposes. Subsequent British legislation shifted the coroner's responsibility to the investigation of deaths due to violence or unnatural means but retained the revenue aspect through a fee payable to the coroner for each inquest held.

Historically, Canada inherited the concepts of a Coroner and of a Coroner's inquest as part of the common law. The common law powers of a coroner to indict persons upon an inquisition for murder or manslaughter, to commit them for trial and to certify evidence were incorporated as part of the Canadian Criminal law in 1892, at which time the indictment function of the inquest was terminated.

The subsequent enactment of Provincial legislation established the jurisdiction and role of the Coroner and continued the coroner's functions of investigating deaths, empanelling juries and conducting inquisitions (inquests). In some provinces and territorial jurisdictions the coroner concept still remains.

With the advancement of the Forensic Sciences and Pathologists specially trained in Forensic Medicine, it seemed logical that with a bulk of reportable cases being medical in nature that instead of reporting to Lay Coroners, that the reporting be done to qualified medical persons. From this evolved the Medical Examiner System.

It was as recently as 1971 that Manitoba enacted and proclaimed THE FATALITY INQUIRIES ACT to replace THE CORONER'S ACT. This statute was reenacted in 1975 and again in 1987 and remained in effect until May 14 th, 1990, when a new FATALITY INQUIRIES ACT was proclaimed.

The distinct features of the current Act are the division of responsibilities into the medical and legal disciplines; the initial inquiry into the cause and manner of death being carried out by a duly qualified medical practitioner; and the inquest, when deemed necessary, being conducted by a Provincial Judge without a jury.

This brief historical background has been provided to explain that in Manitoba the Medical Examiner system, while relatively recent in origin, has been both legislatively and operationally implemented and has fully replaced the Coroner system.

INTRODUCTION

The Office of the Chief Medical Examiner in Manitoba is responsible under the Fatality Inquiries Act and Vital Statistics Act for the inquiry/investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anaesthesia, or within 24 hours of admission, are investigated, as are deaths of persons held involuntarily, and residents of personal care homes. Also, in the event of the death of a child-in-care the Chief Medical Examiner shall review the actions taken by the Child and Family Services agency.

The area of jurisdiction is the province of Manitoba, which has a population of approximately 1.1 million. In addition, the Medical Examiner has jurisdiction over those who travel through the province.

The medical examiner system, under the direction of the Chief Medical Examiner, is managed from a central office located in Winnipeg. The office administers the complete province of Manitoba and has a permanent staff of one administrative officer, three medical investigators, and three administrative secretaries. The fee-for-service element is provided by 76 part-time medical examiners with additional fee-for-service support provided by pathologists, funeral directors and ambulance services.

In the City of Winnipeg, three medical investigators are on duty daily Monday to Friday during standard working hours. Part-time medical examiners are available and on call during the evenings and weekends. Throughout rural Manitoba and in other cities such as Brandon, Thompson, etc., part-time medical examiners are available on an as-required basis 24 hours a day.

Toxicology testing is provided by the Royal Canadian Mounted Police Forensic Laboratory. Other speciality tests are provided on an as-required basis, utilizing outside resources both in and out of the province of Manitoba.

In 1989, 2582 deaths were investigated by the Chief Medical Examiner's office. This represented twenty-nine percent of all deaths in Manitoba during the year. In each case, the report generated by the medical examiner or medical investigator contained information on the cause, manner, identity and age of the deceased, and circumstances surrounding the death. In many cases the police, both RCMP and municipal forces, assist the medical examiners in conducting their investigations.

In January of 1985, the Office of the Chief Medical Examiner became actively involved in the eye donor program. Next of kin were contacted shortly after death and asked to consent to donating the cornea of the deceased. Through the program, regular donations were made available to the Lions Eye Bank.

Appreciation is expressed to all Law Enforcement Agencies and all other related agencies involved who have throughout the year, cooperated and assisted in the investigations which have been processed through this office. Also, gratitude is expressed to all Medical Examiners who, frequently under adverse conditions, have shown a high level of dedication, and professionalism.

Caseload Statistics 1989

TOTAL CASES

CERTIFIED CASES

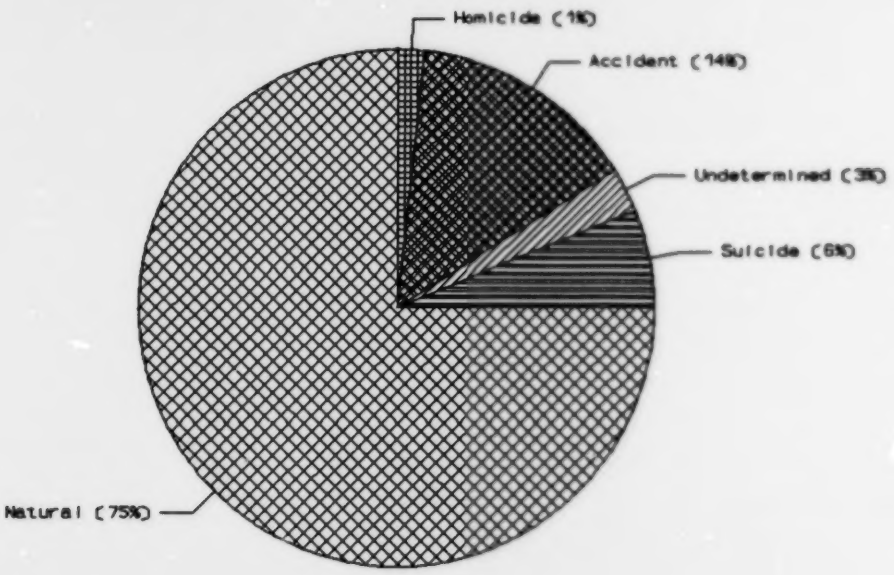
Manner of Death	Cases	Aggregate Rate per 100,000 of Population
Natural	1935	178.4
Accidents:		
In the Home	103	9.5
In Other Places	85	7.8
Industrial	13	1.2
Motor Vehicle	173	15.9
Suicides	158	14.6
Homicides	38	3.5
Undetermined	77	7.1
Total	2582	238.0

Note: 413 Natural deaths were designated Medical Examiner's Investigators cases.

REGIONAL DISTRIBUTION OF CASES

	Urban	Rural	Total
Natural	1557	378	1935
Accidents:			
In the Home	67	36	103
In Other Places	32	53	85
Industrial	8	5	13
Motor Vehicles	62	111	173
Suicides	102	56	158
Homicides	21	17	38
Undetermined	49	28	77
TOTAL	1898	684	2582

MEDICAL EXAMINER CASES



CASELOAD REVIEW 1972 - 1989

YEAR	TOTAL
1972	2320
1973	2409
1974	2409
1975	2604
1976	2653
1977	2758
1978	2667
1979	2627
1980	2480
1981	2683
1982	2480
1983	2545
1984	2386
1985	2522
1986	2605
1987	2503
1988	2541
1989	2582

TYPES OF DEATH
INVESTIGATED AND CERTIFIED

HOMICIDES

	Male	Female	TOTAL
Urban	9	12	21
Rural	12	5	17
TOTAL	21	17	38

AGE / METHOD

Method Age:	0-9	10-19	20-29	30-39	40-49	50-59	OVER 60	TOTAL
Firearms	0	2	7	1	2	2	0	14
Blunt Weapon/ Violence	0	1	3	1	1	1	1	8
Stabbing/ Incised Wound	0	2	4	2	1	2	1	12
Police	0	0	0	0	0	0	0	0
Child Battery	0	0	0	0	0	0	0	0
Other	0	1	1	2	0	0	0	4
TOTAL	0	6	15	6	4	5	2	38

SUICIDES

SEX AGE:	10-19	20-29	30-39	40-49	50-59	60-69	70-79	> 80	TOTAL
MALE									
NON-NATIVE	9	20	19	13	11	13	12	6	103
NATIVE	7	8	3	2	1	0	0	0	21
FEMALE									
NON-NATIVE	1	2	7	5	4	3	2	1	25
NATIVE	3	3	1	2	0	0	0	0	9
TOTAL	20	33	30	22	16	16	14	7	158
RATE/100,000 POPULATION	1.8	3.0	2.8	2.0	1.5	1.5	1.3	0.6	14.6

REGION / MONTH

Month of Death	Urban	Rural	TOTAL
January	9	8	17
February	9	2	11
March	8	4	12
April	8	4	12
May	12	4	16
June	8	4	12
July	8	4	12
August	4	4	8
September	10	5	15
October	10	8	18
November	7	4	11
December	9	5	14
TOTAL	102	56	158

SUICIDE RATES PER 100,000 POPULATION OF MANITOBA BY YEAR

YEAR	Estimated Population (000's)	Total Suicides	Rate per 100,000 of Population
1973	996.2	124	12.45
1974	1007.5	141	14.00
1975	1013.6	141	13.91
1976	1021.5	141	13.80
1977	1027.4	179	17.42
1978	1032.0	155	15.02
1979	1028.3	135	13.13
1980	1024.9	126	12.29
1981	1026.2	151	14.71
1982	1034.5	149	14.40
1983	1048.1	172	16.41
1984	1058.8	151	14.27
1985	1070.6	141	13.17
1986	1071.2	168	15.68
1987	1080.3	172	15.92
1988	1084.0	175	16.14
1989	1084.8	158	14.56

METHOD

	Male	Female	Total	Percentage of Total
Drug overdose/Poison	11	12	23	14.6 %
Carbon Monoxide	15	5	20	12.7 %
Hanging/Strangulation	35	10	45	28.5 %
Drowning	4	2	6	3.8 %
Firearms	48	3	51	32.3 %
Jumping	4	2	6	3.8 %
Other	7	0	7	4.4 %
TOTAL	124	34	158	100 %

NATIONAL SUICIDE RATES PER 100,000 POPULATION OF CANADA 1979 - 1989

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
National Rate	14.1	14.0	14.0	13.9	15.1	13.7	12.9	14.5	14.0	13.5	13.3
NFLD	04.4	03.4	4.2	6.0	6.2	6.7	4.0	4.0	4.9	7.7	5.1
PEI	13.1	11.4	7.4	8.9	12.9	12.0	3.6	11.1	8.6	10.1	8.5
NS	12.6	11.5	10.9	12.2	12.1	9.9	12.0	10.8	12.6	12.0	10.9
NB	12.1	11.6	11.1	12.9	14.2	12.6	12.0	13.5	10.5	15.1	11.7
QUE	15.4	14.8	16.4	16.5	18.5	15.7	17.1	17.6	17.9	16.4	15.6
ONT	13.0	13.1	12.5	12.7	12.9	12.3	11.4	12.4	11.5	11.1	11.9
MAN	14.7	11.8	14.0	13.4	15.8	12.7	11.9	14.3	15.8	14.2	14.6
SASK	14.9	15.9	17.7	17.5	14.9	13.5	13.0	13.7	13.0	14.3	12.3
ALTA	15.4	18.1	15.9	16.2	16.7	17.2	12.6	17.9	16.1	16.7	14.9
BC	16.2	14.8	14.5	15.0	14.8	13.4	10.4	14.7	14.1	12.7	13.7
YUKON	27.0	50.0	22.0	29.0	36.0	23.0	35.0	43.0	28.6	27.8	19.8
NWT	18.0	20.0	22.0	17.0	43.0	34.0	25.0	29.0	28.9	40.2	58.2

Source: Statistics Canada

TRAFFIC ACCIDENTS

Motor Vehicle

- Alcohol related	74
- Alcohol report not done	17
- Not alcohol related	82
TOTAL	173

Vehicle/Pedestrian	23	Vehicle/Train	0
Vehicle/Vehicle	86	Vehicle/Fixed object	0
Single vehicle	48	Multiple vehicle	0
Snowmobile	3	Motorcycle	4
All terrain cycle	2	Vehicle/Motorcycle	5
Minibike/Off road	0	Vehicle/Cyclist	1
Motorhome	0	Other	1

TOTAL TRAFFIC FATALITIES 173

NON-TRAFFIC ACCIDENTS

A. INDUSTRIAL

Farming	1
Mining	1
Other	11
TOTAL	13

B. IN OTHER PLACES

Aircraft	5
Exposure	12
Drowning	31
Carbon monoxide poisoning	5
Falls	13
Hunting	4
Falling objects	1
Other	14
TOTAL	85

C. IN THE HOME

Falls	45
Asphyxia	8
Inhalation burning house	16
Burns/Scalding	5
Electrocution	1
Drugs/Alcohol	17
Inhalation (Sniffing)	0
Cafe Coronary	2
Other	9
TOTAL	103

Total non-traffic accidents	**201**
TOTAL ACCIDENTAL DEATHS	**374**

NATURAL DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Heart Disease	673	352	1025
Cancer	90	47	137
Lung Disease	100	89	189
Haemorrhage	110	85	195
Intra - Operative	14	9	23
Post - Operative	123	74	197
Stillborn	1	1	2
Undetermined	17	11	28
Other	76	63	139
TOTAL	1204	731	1935

AGE GROUP	MALE	FEMALE	TOTAL
Still born	4	2	6
Under 1 year	12	7	19
1 - 9	8	4	12
10 - 19	6	4	10
20 - 29	14	9	23
30 - 39	28	11	39
40 - 49	62	17	79
50 - 59	161	57	218
60 - 69	306	143	449
70 - 79	360	218	578
80 - 89	214	206	420
90 - 99	27	52	79
over 100 years	0	1	1
unknown	2	0	2
TOTAL	1204	731	1935

REPORTS ON CHILDREN - IN - CARE AT TIME OF DEATH

YEAR	MALE	FEMALE	TOTAL
1987	4	7	11
1988	9	3	12
1989	13	9	22

SUDDEN INFANT DEATH SYNDROME

Age Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
0 - 4 Months	1	0	2	2	2	1	1	2	1	2	3	4
5 - 8 Months	0	0	0	0	0	0	0	0	0	0	0	0
9 - 12 Months	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1	0	2	2	2	1	1	2	1	2	3	4

In Manitoba S.I.D.S. accounted for 21 infant deaths in 1989. The overall incidence of S.I.D.S. has been reported as 1 case per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Manitoba is during the first four months.

S.I.D.S. STATISTICS 1977-1989

1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
34	24	21	23	34	22	28	22	23	22	13	17	21

UNDETERMINED* DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Asphyxia	1	2	3
Carbon monoxide poisoning	1	0	1
Drowning	4	3	7
Drugs/Alcohol overdose	9	10	19
Falls	2	0	2
Exposure	0	1	1
Other	16	7	23
TOTAL	33	23	56

* Undetermined as to whether death was a suicide, homicide or an accident.

INQUESTS

INQUESTS SUMMARY
(January 1, 1989 - December 31, 1989)

Judicial Recommendations For the Prevention of Similar Deaths

Manner of Death	Given	Not Given	Not Available
Natural	0	1	0
Homicide	1	0	0
Suicide	1	1	1
Accident	7	2	3
Undetermined	0	1	1
TOTAL	9	5	5

TYPE OF INQUESTS

A. HOSPITAL/INSTITUTIONAL RELATED

Undetermined	1
Accidental	1
Suicide	2
Natural	0
TOTAL	4

B. OCCUPATIONAL RELATED

Accidental	6
TOTAL	6

C. POLICE/INCARCERATION RELATED

Suicide	0
Undetermined	0
Accidental	0
Homicide	0
TOTAL	0

D. SPORTS/RECREATIONAL RELATED

Accidental	2
TOTAL	2

E. OTHER

Homicide/ Suicide	1
Undetermined	1
Accidental	3
Suicide	1
Natural	1
TOTAL	7

TOTAL INQUESTS: 19

Summary of Inquests and Recommendations

(All deaths occurred in 1989)

Case	Description	Judicial Recommendations
1. *Cranio-facial injuries resulting from a motor-vehicle accident*	*Accidental: Deceased was the driver of a Department of Natural Resources (D.N.R) truck that was involved in a head-on collision with another D.N.R. truck. Both trucks were travelling with their headlights off while on a night-lighting investigation.*	*1. That the D.N.R review its practice of allowing its members to drive without lights in the course of night patrol investigations. If the Department determines that a variation on this investigative technique is warranted, the Department should set out written policy guidelines as to the use of this technique, keeping in mind such factors, though not exclusively, provisions of the Highway Traffic Act, regulations under the Wildlife Act and related statutes, investigative equipment both for vehicles and personnel, speed restrictions, communication guidelines and any other factors it deems appropriate.* *2. Such policy is to be submitted to the Workplace Safety and Health Division for their decision on the safety features of the policy for D.N.R employees.*
2. *Crushing injury to the head*	*Accidental: Deceased and co-worker were struck by a train in the course of their duties performing track repair along a C.N.R main line. As they were working, the noise of a grinder in use covered the sound of the whistle of the approaching locomotive.*	*1. That the safety watcher system; the "Buddy System" be part and parcel of the training curriculum. This system is to be monitored on a daily basis and action taken if indeed the buddy system is not pursued.*
3. *Asphyxia - inhalation of smoke*	*Accidental: Deceased died in a house fire which occurred on the Dog Creek Indian Reserve. The Band fire truck was sent to Winnipeg for repairs in mid-August and was ready for pick-up in mid-september, but was not retrieved until December 1st, and was not available at the time of the house fire.*	*Not available.*
4. *Gunshot wound to the head*	*Suicide: Inspector of the Winnipeg Crime Division at the time when J.J. Harper was shot. Deceased was to testify at the Aboriginal Justice Inquiry.*	*Not available.*

Case	Description	Judicial Recommendations
5. Drowning - Asphyxia	*Accidental: Deceased was swimming in West Hawk Lake at Crescent Beach, in a designated swimming area that was unsupervised at the time drowning occurred.*	*1. It is essential that the Department of National Resources, Parks Branch, pay immediate and careful attention to the Beach Patrol Program Review, forwarded to the Assistant Deputy Minister in September 1987.* *2. Some immediate decisions have to be reached with respect to the concept that is to be pursued by the Parks Branch with respect to Beach Safety Programs.* *3. It may be appropriate to consider, where the physical circumstances of a beach site warrants, the establishment of a roped-in area which can be given a level of supervision akin to a swimming pool with lesser degrees of supervision being available to those areas outside the roped-in areas.* *4. It must be recognized that certain beach areas are faced with competing interests on the part of those who use the waters as a means of recreation, and any Beach Safety Program that is entertained must take this into account.* *5. If an investigation by the Parks Branch discloses that very heavy usage of the diving platform is a recurring problem at Crescent Beach, or on other supervised beaches, then it may be appropriate to introduce rules limiting the numbers of people who can attend on these platforms at any given time, and/or consideration might be given to the placement of a Beach Patrol Officer on these platforms at times of heavy usage.* *6. i) The Use of Signs: Whatever concept for beach safety is ultimately adopted, its effectiveness can only be assured if the conditions of beach usage as envisioned by that concept are effectively communicated to those who use the beach. ii) Advertising as a Means of Education: It became evident during the course of the Inquiry that the Beach Safety Program provided by the Parks Branch does not, and probably never has, offered a "life-guarding service" as that term is normally understood. This error in public perception must be laid to rest without delay, and an aggressive advertising campaign should be undertaken by the Parks Branch to advise the public of the details and the limitations of any Beach Safety Program undertaken on their behalf.* *7. Recognizing the need for a line of command, it is understandable that the Beach Patrol mem-*

Case	Description	Judicial Recommendations
		bers ought to be responsible to their Captain, and the Captain, in turn, ought to be responsible to a Natural Resources Officer in the area in which the patrol unit is located.
6. Asthmatic attack - mucus plugging of bronchi as a result of severe asthmatic bronchitis	*Undetermined: Deceased had severe asthma for several years and was placed on a drug study the day prior to death.*	*Not available.*
7. Cardiac failure - Anoxia, congestion and haemorrhage into lungs as a result of the crushing of chest and abdomen after accidentally trapped in a pile of gravel	*Accidental: Deceased was pinned against back of truck, buried up to his shoulders, by an avalanche originating from a shift in the face of an adjacent pile of gravel. While in the process of getting x-rays for injuries sustained in the accident, the deceased suffered a cardiac arrest and expired.*	*None.*
8. Bronco Pneumonia due to foreign object (partial dental plate) in bronchus	*Undetermined: Deceased had no natural teeth, and it was known that the deceased never had any dentures, nor wore any. Origin of the dentures is unknown.*	*None.*
9. Asphyxia - aspiration of food and gastric contents	*Accidental: Deceased collapsed and died after a meal because of an obstructed airway. Deceased had a mental deficit and Moebius Syndrome. Immediate attempts at resuscitation by nursing staff failed to revive the deceased.*	*None.*
10. Multiple injuries from fall	*Accidental: Deceased was an employee of Manitoba Hydro who while in the process of switching power lines from one pole to another, fell 10 metres to the ground from a hydro*	*Not available.*

Case	Description	Judicial Recommendations
	pole work platform.	
11. Lack of oxygen from an upper airway obstruction due to acute epiglottitis and tracheitis	*Natural: An infection, starting as a viral infection, developed into a bacterial infection causing swelling of the airways resulting in bronchial pneumonia. Abrupt deterioration in the condition of the deceased and the remote location at Gods River had affected the necessity of, and the immediate provision of emergency medical assistance.*	*None.*
12. Carbon monoxide poisoning	*Accidental: Deceased was a victim of carbon monoxide poisoning at his residence. The carbon monoxide gas was generated from incomplete combustion in a natural gas system located in the boiler room of the deceased's residence. The incomplete combustion had resulted from the blockage of a combustion air intake duct.*	*1. That regulations be developed by the appropriate governmental authority requiring:* *i) the posting of signs in the boiler rooms or furnace rooms of multi-unit dwellings which clearly warn of the danger of blocking fresh air ducts designed for the supply of oxygen to support combustion in gas heating appliances.* *ii) the owners of multi-unit rental dwellings to provide, periodically, to an appropriate governmental authority, satisfactory evidence of the integrity and the safety of the exhaust ducts and chimney apparatus associated with gas heating appliances.* *2. That I.C.G. Utilities (Manitoba) Ltd. should require its service personnel to carry with them to all service calls of an emergency nature, the apparatus necessary to test for the presence of carbon monoxide gas.* *3. That governmental regulations should require that all mandatory inspections of gas fired appliances, as well as other inspections thereof undertaken by the supplier or installer of natural gas or natural gas appliances following an installation, emergency call or other cause relating to the operation of the firing or firing mechanisms of such appliances, include testing for the presence or production of carbon monoxide.* *4. That the boiler inspections performed by the Department of Labour should be extended to include the inspection of accessibly and visible duct work to or from gas heating appliances through which or from which exhaust may be carried, and should require the repair of any breach in said duct work before said appliances*

Case	Description	Judicial Recommendations
		may be operated or further operated.
13. Air embolism in the brain, heart and large vessels	*Accidental: After completing 3 ascents in depths between 7 to 11 metres, with total under-water time being 26 minutes. While swimming to shore the deceased collapsed, required assistance to reach shore and thereupon expired. Deceased was not diving alone, and was an experienced diver.*	*1. Cautionary Bulletin: The Province's Health Department should issue a cautionary bulletin warning scuba divers of the inherent danger of diving after a respiratory infection which may have caused scarring, constriction or mucous plugging of the small airways of the lungs.* *2. Provisions of an emergency telephone at the West Hawk Lake public campground.* *3. Provision of a designated parking area for emergency vehicles attending the West Hawk Lake public campground.* *4. Training and Certification:* *a) That government certify all persons wishing to become scuba instructors and that such persons be required to re-certify on some sort of regular basis. This intervention would protect the public from unscrupulous, and/or incompetent instructors.* *b) That government impose uniform general certification standards and direct that same be implemented and policed by the aforementioned accredited instructors.* *c) That government require re-certification of all divers on a periodic basis. This could be accomplished by the imposition of a mandatory "expiry date" on all certification cards. Such a provision would safeguard all divers who had suffered a deterioration in health status since their initial certification. It would also protect those whose command of basic principles had diminished for whatever reason, i.e. whether due to memory lapse, lack of on-going involvement, new technological developments, etc.*
14. Mining - electrocution	*Accidental: Deceased was disconnecting a live high voltage joy plug when he received an electric shock.*	*1. A kill switch be installed on all electrical powered equipment that uses a plug connecting cable system.* *2. All power sources be shut off before any plug is disconnected.* *3. A suitable means other than chains or pipes be provided to support electrical cable and prevent wear on the cable.* *4. When moving trail cables, reasonable care be used so as to not create knots in the cable and keep the cable free of mobile equipment.* *5. All personnel working with the equipment connected to power source via plug connecting*

Case	Description	Judicial Recommendations
		cable system should receive updated information, instructions and training as to its proper use and safe handling.
15. Hanging	*Suicide: Deceased was a resident of the Manitoba Developmental Centre who hanged himself.*	*The Provincial Judge was impressed by recommendations made by the Manitoba Developmental Centre, more specifically:* *1. Development of a suicide management protocol.* *2. Establishment of a multi-disciplinary review of all suicide attempts, threats and gestures.* *3. Providing a staff support process.* *4. Suicidology In-service.* *5. Whether or not the Manitoba Developmental Centre is indeed the appropriate milieu to accommodate persons who are known to be chronically suicidal and subsequently very difficult to treat must be considered.*
16. <u>Suicide and multiple Homicide</u>: *i. Gunshot wound to chest and abdomen*	*Homicide: Father shot youngest son (deceased), and wife out in front of their family home during an attempt to escape from father. Eldest brother had been previously shot inside the house moments before.*	*1. That in all cases where abuse, violence or the use of weapons is alleged in a family situation, immediate steps be taken to fully record same in such manner that it be easily retrievable by any social worker or caring agency authorized to work on any file in the system.* *2. That any report to the Child and Family Services of physical abuse, violence or the use of weapons will automatically cause the relevant file to be flagged in such a way that information could be shared on short notice with the police.* *3. That any report to the Child and Family Services of the use of weapons or even the presence of such in a household, where it should have been obvious that one or more of the members of the household was unstable, be forthwith transmitted to the police.* *4. A regular review or conference should be held by supervising staff at Child and Family Services to go over all files reporting abuse, with the object of providing not only a second assessment, but as well to gauge the individual workers' "case load" and his or her ability to carry the load. The evidence strongly suggests that in this case overwork put a strain on the quality of the assessment being made and service rendered.*
ii. Gunshot wound to head	*Homicide: After a violent domestic encounter the deceased was shot by his father, who then chased his wife and other son out of the house fatally shooting both in the front yard.*	
iii. Gunshot wound to axilla and abdomen	*Homicide: The deceased was shot by her husband, while attempting to escape from husband immediately after husband shot deceased's eldest son inside the house.*	
iv. Gunshot wound to head	*Suicide: Deceased committed suicide after killing his wife and two sons, then holding the Winnipeg Police at bay for a period of 47 hours.*	

Case	Description	Judicial Recommendations
17. Multiple injuries	*Accidental: Deceased was operating a drill rig on the Trans-Canada pipeline. Deceased had drilled into a hole containing explosives which had misfired during a previous right of way blasting operation. The misfired hole detonated striking deceased with rock fragments and propelled deceased 16 metres.*	*Not available.*
18. Crushing injuries	*Accidental: Deceased was an employee of the City of Winnipeg who was operating an eight-wheel vehicle called a "road packer" on a newly constructed street too close to the shoulder causing it to roll onto its side. It came to rest upside down with the deceased crushed between the seat, steering wheel and the ground. Deceased started operating the packer two days prior to the accident.*	*1. The City of Winnipeg examine the qualifications and standards for operating road packers.* *2. The City of Winnipeg examine the feasibility of including the training of the operators of such equipment within their training program.* *3. The City of Winnipeg examine the feasibility of insisting upon such equipment possessing a roll-over protection structure.*
19. Hanging	*Suicide: Deceased had a long history of mental illness. While out on an unescorted two day pass, deceased was found hanging by neck by means of a scarf in her residence. No indication of suicidal tendencies on the day of release.*	*None.*